

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Columbus Manor Residential Care Home# 0007781 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>189</u>	Intermediate (ICF)	<u>189</u>	<u>68,985</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>189</u>	TOTALS	<u>189</u>	<u>68,985</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>58,035</u>			<u>58,035</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>58,035</u>			<u>58,035</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.13%

D. How many bed-hold days during this year were paid by the Department?

1,176 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐I. On what date did you start providing long term care at this location?
Date started 0/0/66

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 5/1/1979 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary None

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	120,546	8,034	6,221	134,801		134,801		134,801		1
2	Food Purchase		314,581		314,581	(24,380)	290,201		290,201		2
3	Housekeeping	79,745	18,293	4,531	102,569		102,569		102,569		3
4	Laundry	17,906	17,215	3,751	38,872		38,872		38,872		4
5	Heat and Other Utilities			113,164	113,164		113,164		113,164		5
6	Maintenance	89,892	16,223	121,408	227,523		227,523		227,523		6
7	Other (specify):*										7
8	TOTAL General Services	308,089	374,346	249,075	931,510	(24,380)	907,130		907,130		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	838,926	19,522	30,533	888,981		888,981		888,981		10
10a	Therapy										10a
11	Activities	114,312	3,586	37,691	155,589		155,589		155,589		11
12	Social Services	54,095		40,375	94,470		94,470		94,470		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,007,333	23,108	108,599	1,139,040		1,139,040		1,139,040		16
	C. General Administration										
17	Administrative	82,125		6,299	88,424		88,424		88,424		17
18	Directors Fees										18
19	Professional Services			52,673	52,673		52,673		52,673		19
20	Dues, Fees, Subscriptions & Promotions			27,970	27,970		27,970	(571)	27,399		20
21	Clerical & General Office Expenses	66,787		19,535	86,322		86,322	(3,608)	82,714		21
22	Employee Benefits & Payroll Taxes			164,364	164,364	24,380	188,744		188,744		22
23	Inservice Training & Education										23
24	Travel and Seminar			345	345		345		345		24
25	Other Admin. Staff Transportation			12,932	12,932		12,932	(600)	12,332		25
26	Insurance-Prop.Liab.Malpractice			135,296	135,296		135,296	(1,326)	133,970		26
27	Other (specify):* Contributions			20,675	20,675		20,675	(20,675)			27
28	TOTAL General Administration	148,912		440,089	589,001	24,380	613,381	(26,780)	586,601		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,464,334	397,454	797,763	2,659,551		2,659,551	(26,780)	2,632,771		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,426	13,426		13,426	13,333	26,759			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			512	512		512	200,473	200,985			32
33	Real Estate Taxes			78,384	78,384		78,384		78,384			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* State Income Tax			13,955	13,955		13,955	(13,955)				36
37	TOTAL Ownership			586,277	586,277		586,277	(280,149)	306,128			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,223	501,752	515,975		515,975		515,975			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,478	103,478		103,478		103,478			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		14,223	605,230	619,453		619,453		619,453			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,464,334	411,677	1,989,270	3,865,281		3,865,281	(306,929)	3,558,352			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/05

Ending:

12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(512)	32-3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(3,608)	21-3		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)	(600)	25-3		16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(20,675)	27-3		20
21 Owner or Key-Man Insurance	(1,326)	26-3		21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax	(13,955)	36-3		26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising	(571)	20-3		28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,247)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	(265,682)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (265,682)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (306,929)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Columbus Manor Residential Care HomeID# 0007781Report Period Beginning: 1/1/05Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/05

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Columbus Manor Residential Care Home# 0007781

Report Period Beginning:

1/1/05

Ending:

12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Patrick J. O'Brien	50%					
Daniel J. O'Brien	50%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 480,000	CM LLC	0.00%	\$	(480,000)	1
2	V	30 Depreciation		CM LLC	0.00%	13,333	13,333	2
3	V	32 Loan Interest		CM LLC	0.00%	200,985	200,985	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 214,318	\$ * (265,682)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Patrick J. O'Brien	Administrator	CEO Administrator	0.00	None	40	100.00	Salary & Bonus	\$ 88,424	17-4	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 88,424		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Columbus Manor Residential Care Home**# **0007781**Report Period Beginning: **1/1/05**Ending: **12/31/05****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																				
1. Real Estate Tax accrual used on 2004 report.		\$ 80,515	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 78,384	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,131)	3																																	
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 80,515	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 78,384	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td>71,863</td><td>8</td></tr> <tr><td>2001</td><td>73,732</td><td>9</td></tr> <tr><td>2002</td><td>74,559</td><td>10</td></tr> <tr><td>2003</td><td>76,681</td><td>11</td></tr> <tr><td>2004</td><td>78,909</td><td>12</td></tr> </table>	2000	71,863	8	2001	73,732	9	2002	74,559	10	2003	76,681	11	2004	78,909	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2000	71,863	8																																		
2001	73,732	9																																		
2002	74,559	10																																		
2003	76,681	11																																		
2004	78,909	12																																		
FOR OHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE	
TO: Long Term Care Facilities with Real Estate Tax Rates	RE: 2004 REAL ESTATE TAX COST DOCUMENTATION
<p>In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.</p> <p>Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.</p> <p>Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,</p>	

FACILITY NAME Columbus Manor Residential Care Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007781

CONTACT PERSON REGARDING THIS REPORT Patrick J. O'Brien

TELEPHONE (773) 378-5490 FAX #: (773) 378-7860

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the real estate tax cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

41,308

B.

General Construction Type:

Exterior

Brick

Frame

Fire Resistant

Number of Stories

2

C.

Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building Site	41,988	1965-1978	\$ 34,000	1
2					2
3	TOTALS	41,988		\$ 34,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	129	1965	1955	\$ 179,090	\$	30	\$	\$	179,090
5	12		1969	67,135		30			67,135
6	48	1969	1973	401,170		30			401,170
7									
8									
Improvement Type**									
9	Sidewalk		1966	1,309		20			1,309
10	Sidewalk		1967	1,819		20			1,819
11	Fence		1970	5,795		15			5,795
12	Remodeling		1970	26,600		30			26,600
13	Sprinkler System		1971	39,406		25			39,406
14	Tile Flooring		1971	12,097		20			12,097
15	Additions		1972	89,417		30			89,417
16	Stairs Porch Enclosed		1972	19,211		30			19,211
17	Roofing Replaced		1972	3,783		30			3,783
18	Canopy		1972	1,339		20			1,339
19	Fencing		1972	2,016		15			2,016
20	Tile Floors		1973	4,718		20			4,718
21	Additions		1974	30,006		30			30,006
22	Chain Link Fence		1974	3,589		15			3,589
23	Sprinkler System		1974	4,664		25			4,664
24	Nurses Station		1975	15,635		20			15,635
25	Switching Tiling		1975	13,706		20			13,706
26	Additions		1976	14,351	247	30	247		14,104
27	Plumbing and Heating		1976	20,000		25			20,000
28	Tiles & Toilets		1976	39,685		20			39,685
29	Sprinkler System		1976	1,868		25			1,868
30	Tops & Caulking		1976	52,683		20			52,683
31	Tile		1976	6,796		20			6,796
32	Retile Building		1977	53,525		20			53,525
33	Plastering		1977	10,920		20			10,920
34	Carpentry		1978	5,152		20			5,152
35	Tile		1978	11,775		20			11,775
36	Tuckpointing		1980	5,600		20			5,600

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Hot Water Heater	1981	\$ 971	\$		\$	\$	\$ 971	37
38	Doors, etc.	1981	1,360		20			1,360	38
39	Ceramic Tile	1981	24,262		20			24,262	39
40	Additions	1982	14,743		20			14,743	40
41	Windows	1983	13,166		20			13,166	41
42	Windows	1987	2,365	118	20	118		2,185	42
43	Cameras	1987	1,091	55	20	55		1,013	43
44	Roof Improvement	1988	3,700	185	20	185		3,237	44
45	Heater	1990	1,240		10			1,240	45
46	Doors, etc.	1990	3,543	177	20	177		2,745	46
47	Electrical	1990	2,202	110	20	110		1,706	47
48	Exit Doors	1991	19,211	961	20	961		13,931	48
49	Doors, etc.	1991	14,655	733	20	733		10,627	49
50	Electrical	1991	3,507	175	20	175		2,540	50
51	New Door	1992	1,330	67	20	67		901	51
52	Roof Improvement	1992	8,950	448	20	448		6,045	52
53	Windows	1992	3,150	158	20	158		2,130	53
54	Exit/Interior Doors	1993	6,100	305	20	305		3,509	54
55	Remodel Nurses' Station	1994	16,000	800	20	800		9,600	55
56	Outside Door	1994	2,882	144	20	144		1,729	56
57	Remodel Nurses' Station	1994	20,300	1,015	20	1,015		12,180	57
58	Roof Replacement	1995	28,751	1,438	20	1,438		15,816	58
59	Remodel Nurses' Station	1995	17,710	886	20	886		9,744	59
60	Generator	1998	80,000	8,000	10	8,000		64,000	60
61	Air Conditioner/Monitor	1998	2,098	210	10	210		1,680	61
62	Hydra Electric	1999	900	90	20	90		540	62
63	DeCarlo Construction	1999	4,900	245	20	245		1,715	63
64	Storm Windows	1999	6,059	303	20	303		2,121	64
65	Wall Repair	1999	3,098	155	20	155		1,085	65
66	AC Prep	1999	1,824	92	20	92		644	66
67	New Fans	1999	1,932	97	20	97		679	67
68	AC Prep	1999	2,168	109	20	109		763	68
69	Exhaust Fans	1999	9,450	473	20	473		3,311	69
70	TOTAL (lines 4 thru 69)		\$ 1,468,478	\$ 17,796		\$ 17,796	\$	\$ 1,376,531	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,468,478	\$ 17,796		\$ 17,796	\$	\$ 1,376,531	1
2	Radiator	2000	10,900	545	20	545		3,270	2
3	PTAK Unit	2000	8,606	430	20	430		2,580	3
4	Four Baseboard Heaters	2001	1,778	89	20	89		401	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,489,762	\$ 18,860		\$ 18,860	\$	\$ 1,382,782	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/05 Ending: 12/31/05
 XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 344,318	\$ 19,407	\$ 19,407	\$	10/30	\$ 174,806	71
72	Current Year Purchases	3,836	192	192		10	192	72
73	Fully Depreciated Assets	1,146,046				15/20	1,146,046	73
74								74
75	TOTALS	\$ 1,494,200	\$ 19,599	\$ 19,599	\$		\$ 1,321,044	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	Volvo 2002	2002	\$ 37,870	\$ 3,787	\$ 3,787	\$	10	\$ 13,255	76
77	Facility Business	Ford Crown Victoria 2003	2003	26,470	2,647	2,647		10	6,617	77
78										78
79										79
80	TOTALS			\$ 64,340	\$ 6,434	\$ 6,434	\$		\$ 19,872	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,082,302	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,893	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,893	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,723,698	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <input type="text"/></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <input type="text"/></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning: 1/1/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 463,632	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	879,835		3
4	Supply Inventory (priced at)	1,800		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,519		6
7	Other Prepaid Expenses	2,290		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,364,076	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	757,423		15
16	Equipment, at Historical Cost	626,617		16
17	Accumulated Depreciation (book methods)	(1,103,552)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 280,488	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,644,564	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 138,356	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,738		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,515		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 276,609	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 276,620	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,367,944	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,644,564	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,056,921	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,056,921	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	894,623	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(583,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 311,023	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,367,944	24

*

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning: 1/1/05

Ending:

12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,731,793	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,731,793	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	26,332	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	627	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26,959	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,152	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,152	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,759,904	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	923,015	31
32	Health Care	1,139,040	32
33	General Administration	700,974	33
B. Capital Expense			
34	Ownership	586,277	34
C. Ancillary Expense			
35	Special Cost Centers	515,975	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,865,281	40
41	Income before Income Taxes (line 30 minus line 40)**	894,623	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 894,623	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning: 1/1/05

Ending: 12/31/05

12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,400	1,520	\$ 42,832	\$ 28.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,318	3,758	87,065	23.17	3
4	Licensed Practical Nurses	17,744	19,376	379,167	19.57	4
5	CNAs & Orderlies	33,087	36,367	326,998	8.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,787	2,007	20,745	10.34	9
10	Activity Assistants	7,756	8,484	93,012	10.96	10
11	Social Service Workers	2,856	2,920	55,137	18.88	11
12	Dietician					12
13	Food Service Supervisor	1,763	2,019	26,043	12.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,659	9,790	94,053	9.61	15
16	Dishwashers					16
17	Maintenance Workers	5,894	6,454	90,160	13.97	17
18	Housekeepers	7,370	8,418	79,553	9.45	18
19	Laundry	1,857	2,041	17,839	8.74	19
20	Administrator	2,032	2,080	81,900	39.38	20
21	Assistant Administrator	2,752	2,816	64,757	23.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,275	108,050	\$ 1,459,261 *	\$ 13.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	177	\$ 6,221	1-3	35
36	Medical Director				36
37	Medical Records Consultant	538	20,378	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	307	10,758	11-3	44
45	Social Service Consultant	1,615	40,375	12-3	45
46	Other(specify) Computer Consultant	91	5,000	19-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,728	\$ 82,732		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Columbus Manor Residential Care Home**# **0007781**Report Period Beginning: **1/1/05**Ending: **12/31/05****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description			Description	Amount
Patrick J. O'Brien		0	\$ 82,125	Workers' Compensation Insurance	\$ 28,368		IDPH License Fee	\$ 200
				Unemployment Compensation Insurance	21,233		Advertising: Employee Recruitment	10,727
				FICA Taxes	111,947		Health Care Worker Background Check	
				Employee Health Insurance	0		(Indicate # of checks performed <u>1</u>)	100
				Employee Meals			IL Secretary of State-Annual Rpt Fee	100
				Illinois Municipal Retirement Fund (IMRF)*	0		Chicago Dept. of Revenue-License/Fee	1,100
				Chicago Dept. of Revenue	2,816		Illinois Council on LTC - Dues	13,853
							Illinois Dept. of Public Aid-Lic. Renewal	1,790
							Department of Prof. Regulators	100
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()
(List each licensed administrator separately.)			\$ 82,125				Non-allowable advertising	()
B. Administrative - Other							Yellow page advertising	(571)
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)	
Bonus			\$ 6,299				\$ 27,399	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 6,299	TOTAL (agree to Schedule V, line 22, col.8)		\$ 164,364		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Canon Fire Protection	Fire		\$ 860					
Illinois Fire Protection	Fire		413					
Zoller, Swanson & Co.	Accounting		46,400				In-State Travel	
Kim Nguyen	Computer Consulting		5,000					
							Seminar Expense	345
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 52,673				\$ 345	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Manor Residential Care Home

STATE OF ILLINOIS

0007781

Report Period Beginning:

1/1/05

Ending:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 103,478
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 24,380 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.